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Challenges in Healthcare in Multi-Ethnic Societies: Communication as a Barrier to Achieving Health Equity

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1. Introduction

The main learning objectives of this chapter are to gain knowledge and a better understanding of:

- Health and migration
- Migration and the challenges for healthcare services
- Equity in healthcare services
- Barriers to communication
- The use of interpreters in healthcare

2. Health and migration

Over 200 million people celebrated their last birthday outside their country of birth, characterizing the sheer scale, scope and extent of migration. The international migrant population (those living outside their country of birth) in 2010 was estimated at 214 million (3.1% of the global population), whereas UNDP has estimated that 740 million migrated within their country of birth. 75% of all international migrants are in 12% of all countries (IOM, 2002). Migration, globalization intensified by rapid transportation and communication technologies, and trade and commerce have all contributed to the evolving multicultural societies in nations all over the world. Modern day societies are characterized as being heterogeneous with increasing complexities of the heterogeneity.

As a part of this global development, West European countries, including Scandinavian countries, have become increasingly multicultural over the last few decades. In Norway half a million immigrants account for 12.2 % of the total population. In Oslo, the immigrant population stands at 28 %, the highest proportion in Norway (Statistics Norway, 2012). A consequence of these demographic changes is the challenge host societies face in integrating non-Western immigrant groups into existing healthcare services; the language barrier is the primary challenge for meeting the healthcare needs of the immigrant population.

3. Challenges in healthcare in multi-ethnic societies

Multicultural societies are often societies in transition that might be undergoing enormous changes. However, the changes are far from unidirectional, being positive and/or negative.

When migrants and their offspring are compared with other groups, changing socio-economic circumstances within and between generations in different migrant and ethnic groups can be linked to changing health patterns (Macbeth, 2001). This suggests that the health of adults might be related to exposures across their life course (Ben-Shlomo, 2004). The circumstances of migration and the social and health characteristics of resettlement are also key determinants of health (Wolffers, 2003). Post-migration determinants of health include the type of work migrants are expected to perform in the host country, the physical and housing conditions available to them, their language skills, remaining in contact with family, acquiring a new social network and their access to health and social services (Carballo M, 2004).

A recent epidemiological study in Norway, "The Oslo Immigrant Health Study", documents the health of migrants at the population level for the first time and indicates that the health of immigrant groups differs greatly compared to Norwegians and even more so with each other (Kumar, 2008). Only 30% of immigrant women from Pakistan and Turkey in the 59/60 year age group reported good health (Kumar, 2008). In all ethnic groups those with the highest education reported good health more frequently than others. Women reported more musculoskeletal disorders than men. However, men had higher proportions of myocardial infarction and stroke. Immigrant groups report mental distress more often than Norwegians, especially immigrant women (Kumar, 2008f) General obesity is a challenge for Turkish and Pakistani women in Oslo, as around 50% were obese (Body Mass Index >30). This is far higher than any of the other ethnic/gender groups. On the other hand, we found Vietnamese men and women with almost no obesity (3-4%).

Children of migrants are often caught at the crossroads between the majority (host) and minority (immigrant) cultures. Ethnic adolescents, therefore, land in **double jeopardy** with persisting unhealthy habits from their minority cultures and acquiring unhealthy habits from the majority as well. This is well illustrated in the case of boys from the Indian subcontinent in Oslo with high consumption of both full fat milk and carbonated soft drinks (Kumar, 2004f). Often the ability of children of migrants to adapt and adopt the host language and culture creates a perceived gap between them and their parents. Their immigrant parents fear that they are distancing themselves from their native values and behavioural patterns. The intra familial stress and parent-child conflicts may be precursors to low self-esteem, feelings of guilt and psychosocial morbidity among children of migrants (Kumar, 2010).

The poor health of immigrants is also reflected in their frequent use of health services. In the Oslo Immigrant Health Study, immigrants made a greater number of visits to the general practitioner (GP) and specialists compared to Norwegians. Turkish and Iranians visited the psychiatrist/psychologist most frequently. Emergency services were used most frequently by those from Turkey and least by the Norwegians (Kumar, 2008). Increased use of healthcare services may reflect: higher prevalence of mental distress related to lifestyle conditions among immigrants, reasons other than health problems cited when using health services or that their need for satisfactory healthcare is not met (FHI 2008). Particular challenges for migrants, such as language barriers, might be a contributing factor to ineffective communication and the increased use of healthcare services (Schyve, 2007).

Further analysis of the situation is recommended to gain a better understanding of the causes of this situation and to devise strategies to cope with it.

4. Equity in health and healthcare

4.1 The concepts of equity

Equity and equality are two concepts that are closely related, but not one and the same. While equality is well-defined, easily understood and measured, equity is not. Whitehead's definition of inequity refers to differences in health that are unnecessary and avoidable, and unfair and unjust (1985). While situations defined as unfair and unjust will vary depending on the place and time one has to examine the cause and judge the unfairness of the situation within the context of that particular society. Equity in health thus means that *every individual has a fair chance to attain their full health potential and, that no one should be disadvantaged from achieving this potential, if it can be avoided (p. 7)*

Therefore, the aim of policy for equity in health is to reduce or eliminate those health differences which result from factors which are considered to be both avoidable and unfair by creating equal opportunities for health and bringing health differentials down to the lowest level possible (Whitehead, 1985).

Braveman and Gruskin define equity as *the absence of disparities in health (or in the major social determinants of health) between social groups who have different levels of underlying social advantage/disadvantage - that is, different positions in the social hierarchy* (P. 254 2003). Populations who are already socially disadvantaged or socially excluded (for example, persons who are unemployed, homeless or members of a disenfranchised racial, ethnic or religious group) are at a further disadvantage with respect to their health. Social disadvantage here refers to two important attributes: the lower social hierarchy and less economically privileged position (or deprivation which can be relative or absolute). Equity has an ethical aspect which is based on the principle of distributive justice and linked to human rights, and can be assessed by comparing health and its social determinants among different more or less advantaged social groups.

4.2 Equity in healthcare

In practice equity means equal access to care, equal utilization for equal need and equal quality of care for all (Whitehead, 1985). Equal access to available care implies equal rights to the available services for everyone and a fair distribution of resources based on healthcare needs. Inequities in access arise when resources and facilities are unevenly distributed, for instance, greater availability in urban areas compared to scarce availability in deprived and rural areas. "Inconvenient" openings hour for clinics, communication barriers and large geographical distances and transport expenses can also be obstacles to equal access to health services.

While studies have documented over- or under-utilization of health services, further studies are required to understand better why the utilization rates are different. The variations in the utilization of services are not only indicators of inequities, but also related to the quality of services.

Equal quality of care for all means that providers must ensure that everyone gets the same high standard of professional care. However, when healthcare providers do not offer the same standards and quality of care to all individuals regardless of age, gender, religious belief or ethnic background, inequities will inevitably arise (Whitehead, 1985). Studies illustrating this phenomenon document negative health outcomes for the children of Spanish-speaking Latinos because of language barriers (Clemans-Cope et al., 2007). Language barriers preventing equal access to healthcare will be dealt with in further detail later in this chapter.

4.3 Equity in health policy

Health policies must address social determinants of health, such as improving living conditions, unemployment and working conditions of underprivileged groups, in order to achieve equity in health and healthcare services. These policies need to acknowledge that some groups in society are more disadvantaged than others. Hence, they face greater restrictions in their lifestyle choices, e.g., inadequate income and/or lower levels of education, which in turn limits where and how people live. Therefore, policies should enable people to adopt healthier lifestyles by increasing access to healthier lifestyles. (Whitehead, 1985)

An important aspect of achieving equity is to ensure user participation, involvement and empowerment, and to avoid a top down approach. This means that administrators need to make efforts to ensure that information is accessible to all, thereby making it easier for users to participate and influence the decision-making process. An important prerequisite in developing and improving equity is providing evidence by identifying the needs of different vulnerable groups. Research is also needed to monitor and evaluate the effectiveness of policies. An intersectoral approach is recommended as the determinants of inequities may be inherent in many other sectors in society (Shaw et al., 2006; Whitehead, 1985).

> "*What the scalpel is to the surgeon, words are to the clinicians…*
> *The conversation between doctor and patient is the hearth of the practice of medicine.*"
>
> Woloshin et al. 1995:72

5. Communication barriers preventing equity in healthcare

The increasing number of immigrants from economically less privileged parts of the world to both Western Europe and Northern America, and the diversity this represents is often perceived as a challenge to existing healthcare services, which were traditionally organized to cover the needs of the native population. One of the most important challenges in

healthcare is to be able to meet the needs of patients from immigrant backgrounds who are not proficient in the language used in the host country.

It is not only language barriers which may represent a challenge in healthcare, but also cultural differences in the perception of health/sickness and the sickness role, experiences of illness, help-seeking behaviour and health literacy level. These differences should not go unnoticed or be under-recognized. A language difficulty is perhaps the easiest problem to detect because it is often the most obvious one. Even so, there are usually no common procedures for systematically assessing the need for language assistance and ensuring adequate help. The healthcare providers, who usually have little or no training in how to evaluate patients' language abilities and often have no clear procedures for how to follow up after facing language barriers, seem often to be left alone to make the decisions themselves (Kale et al., 2010a). Even when a professional interpreter is attained, communication problems can arise due to lack of knowledge and skills on the part of healthcare provider regarding how to work together with the interpreter for optimal communication (Kale et al., 2010b). Healthcare institutions have responsibilities to ensure competency and procedures in their organizations in order to be able to give optimal health services to diverse populations for equal access and quality care for all.

5.1 Health literacy

Along with language barriers to effective communication in healthcare there are other potential barriers. Inadequate health literacy of patients is one of the reasons for difficulties in communicating effectively the treatment procedures or prescriptions in consultations and non-compliance. Health literacy refers to a mismatch between the healthcare provider's level of communication and the patient's level of comprehension of the medical information given to them (Weiss, 2003). Health literacy is not the same as literacy and is described elsewhere as an individual's ability to read, understand and use basic health information and services to critically evaluate the information and make appropriate health decisions. Health literacy requires a group of abilities like reading, understanding, remembering the information obtained, analysing and decision-making skills. For instance, the ability to read and understand prescription instructions, understanding informational materials and brochures, filling out forms and so on.

We do not have any statistics in Scandinavia, but according to the first large scale assessment done in 2003 in the USA, 21% of the adult population have basic and 14% below basic health literacy, while the majority (53 %) had intermediate health literacy (Kutner et al., 2006). In this study White and Asian/Pacific Islander adults had higher average health literacy than Black, Hispanic American Indian/Alaska Native and Multiracial adults. It has been shown that patients with low health literacy have less awareness of preventive health knowledge, less knowledge of their medical status and self-care instructions compared to people who are more literate (Weiss, 2003). This is an especially crucial issue for immigrant patients who are in a vulnerable position because of difficulties in getting the information they need in a language they can comprehend. In fact, elderly people, people with low socioeconomic status, unemployed people, minority ethnic groups and individuals who have recently immigrated and do not speak the majority language or have the majority language as their second language are in the risk group for low health literacy (Weiss, 2003)

(Ref: http://talk.onevietnam.org/vietnamese-americans-and-health-literacy-ready/

5.2 Language barriers

There are many models of how human communication proceeds between people from the simplistic and mechanical transmission model where a message is sent to f.exp. verbally from the so called "encoder" or sender to the "decoder" or receiver, to a more complex linear model of the Sender-message-Channel-Receiver Model (SMCR) of communication. There are also models which use a constructivist point of view in which communication is perceived as a collaborative and joint activity where reciprocally in the interaction is emphasized (Clark, 2007). When analysing communication, regardless of which communication model one employs to conceptualize the communication between people, one can still think of plenty of reasons why barriers to effective communication between the patient and healthcare provider arise in addition to lack of a common language, for instance, message *overload* (when a person receives too many messages at the same time) and *message complexity and misunderstanding* due to language-related factors (semantic or syntactical) and different perspectives because of cultural differences between the participants (Montana et al., 2008).

Cultural barriers might arise in meetings with migrants depending on what patients bring to the consultations such as their personality, earlier experiences, habits, attitudes, beliefs and prejudices. To a large extent these characteristics are shaped both by the society they belong to and are currently part of and therefore will be an integral part of the ongoing communication and thus also influence the future course of action. It is also about what the healthcare provider has in terms of personal cultural baggage, e.g., the *professional culture* he/she belongs to, as well as the *organizational or institutional culture* in which the interactions are embedded (Helman, 2001).

There has been increasing awareness about that the attitudes of therapists from majority populations with regard to various minorities and how this may influence diagnostic practices and the quality of the treatment provided (IOM 2002, ACP 2010). These reports document that minority patients have less access to necessary health services than White patients from the majority. Relatively significant differences in the treatment of various diseases were pointed out, for example, with regard to cancer, cardiovascular diseases, diabetes and psychiatric disorders among minorities, to the disadvantage of these patients. It is assumed that several factors could explain these differences, including health service organizations and consultation practices, of which the clinical uncertainty of physicians, caused by limited information/time constraints and negative attitudes to minority patients, may have a decisive impact.

It is essential that healthcare providers and patients communicate effectively to ensure that patients get proper help. Effective communication is defined as communication that is "*comprehended by both participants; it is usually bidirectional between participants, and enables both participants to clarify the intended message*" (Schyve & The Joint Commission, 2007, p.360) and requires a vast repertoire of skills in interpersonal processing like listening, observing, speaking, analysing and evaluating, all of which enable collaboration and cooperation. "*In the absence of comprehension, effective communication does not occur; when effective communication is absent, the provision of health care proceeds only with errors, poor quality, and risks to patient safety*" (p.360).

Ideally communication should be in the same language to be able to communicate efficiently and when not possible with qualified language assistance (i.e., using professional interpreters). Doctors view culture, ethnicity and language difficulties as barriers to both effective physician-patient communication and a satisfying working alliance (Johnson et al., 2004; Laveist et al., 2002; Meeuwesen et al., 2006). Immigrant patients living in Scandinavia report similar experiences in the existing studies. They complain about not being understood because of language problems and cultural differences, not having enough time to explain their problem and the doctors not being interested in their worries and concerns (Grønseth, 2006; Nielsen, 2005)

For many years the communication between physicians and patients has been made a topic in studies from different perspectives (Zimmermann et al., 2007; Kale et al., 2011). In a review article based on selected peer-reviewed studies of communication between physicians from majority populations and patients from a non-Western background, Schouten & Meeuwesen (2006) conclude that the research results obtained to date indicate considerable communication problems. Research also shows that healthcare workers underestimate the negative impact of language barriers and underuse interpreter services (Bischoff et al., 2010; Kale et al., 2010a).

The negative consequences of language-based obstacles in intercultural communication in healthcare are documented to some extent, but far less than adequately and seldom systematically (Divi et al., 2007). In Scandinavia, the consequences of poor communication between healthcare professionals and minority patients have only to some extent been discussed. For instance Essen (2001) examined stillbirths among women from Somalia, Ethiopia and Eritrea and found a lower quality of prenatal care in immigrant populations compared with the majority population. She pointed out the infrequent use of interpreters in the delivery ward as one of the most important reasons for the reduced quality of care.

Divi et al. (2007) point exactly to this lack of interest researchers have shown in this issue by referring to what Johnstone and Kanitsaki said in their article from 2004: '*…there is a paucity of literature specifically addressing the critical relationship that exists between culture, language, and patient safety, and the particular risks that patients from minority racial, ethno-cultural, and language backgrounds face when being cared for by healthcare professionals who do not know about, share, or understand either their culture or language*'

In order to fill this knowledge gap to some extent, Divi et al. (2007) studied the type and frequency of adverse events experienced by patients with Limited English Proficiency (LEP) and English-speaking patients in six U.S. hospitals. The findings showed that LEP hospital patients are more likely than their English-speaking counterparts to experience adverse events that result in harm, and the severity of that harm is often greater. Among 251 adverse events involving patients with LEP, 130 (52%) were related to communication problems whereas 36% of adverse events with English–speaking patients were related to communication problems.

- Misunderstandings and difficulties in uncovering misunderstandings
- Problems with giving preventive health information and in getting informed consent
- Difficulties with involving patients in their treatment and decision-making
- Inadequate comprehension of diagnoses and treatment
- Increased risk of misdiagnosis - both over- or under-diagnosis
- Inappropriate treatment or lack of treatment
- Over or underuse of healthcare services
- Increased use of unnecessary diagnostic resources
- Less adherence
- Frustrations and less satisfaction on both sides

Box 1. Potential negative effects of language barriers in healthcare (Jacobs et al., 2004; Moreno & Morales, 2010; Flores, 2003; 2005; Ngo-Metzer, 2003)

5.3 The use of interpreter services in order to overcome language problems

There is general agreement that a desirable way to overcome language barriers is the use of a professional interpreter. The widespread practice of using non-professionals, family members or friends, or bilingual staff on an ad hoc basis as interpreters has been

discouraged (Frederics, 1996; Jareg et al., 2006). This is because emotional ties between the patient and their family and friends can interfere with the interpretation. Furthermore, non-professional interpreters cannot be expected to have adequate knowledge of medical terminology or a good enough command of both languages needed in order to impart the correct information. The patient's right of confidentiality and privacy may be breached if the patient feels forced to accept the presence of a family member as interpreter. Further, their presence can inhibit discussions regarding sensitive issues such as domestic violence, sexual abuse, psychiatric illness and other sensitive health problems like sexually transmitted diseases (Flores, 2003; 2005). Moreover, the use of a patient's minor-aged children in planned or acute consultations would be especially unethical and professionally irresponsible, not least towards the child, with regard to the child's best interests. This can even be against the principles of the conventions on the Rights of Children (Jareg & Pettersen, 2006)

5.3.1 "We take what we have": A questionnaire-based survey about the use of interpreters in Oslo

This title is an answer from one of the healthcare providers which describes the situation quite well considering what they usually do when language assistance is encountered with their patients. Although communication and language barriers between healthcare workers and patients have recently received attention internationally, in Scandinavia few studies have documented what healthcare workers do when they encounter language obstacles, the expectations they have of the interpreters and their evaluation of their own needs. Therefore, a questionnaire-based survey using a cross-sectional design was conducted with healthcare providers working at hospitals in Oslo as participants during 2004-2005.

Even though the immigrant's right to have a professional interpreter in encounters with the public health sector can be considered weakly anchored in existing legislation in several countries, there has been an increased emphasis on patient rights and the legal strengthening of these rights in Scandinavia, as well as in other Western countries. For instance according to the Patient Rights Law in Norway (1999), the patient has the right to contribute to or facilitate the consultation with the healthcare worker and the right to contribute to the choice of the available examinations and treatment methods. In order to be able to contribute, it is stated that information should be adapted to the patient's individual conditions, such as age, maturity, experience, culture and language background. In addition, healthcare workers are to ensure, to the best of their ability, that the patient has understood the content and meaning of the information.

The fact that responsibility is placed on the healthcare workers to evaluate the need for a professional interpreter emphasizes the importance of investigating the associated factors and situations related to this evaluation process and describe the common practices among healthcare workers. With that aim a cross-sectional survey study was conducted using a structured questionnaire in Oslo a few years ago. The survey was distributed to all general practitioners (GPs) at the primary care clinics in the three city districts in Oslo that have the highest percentage of non-Western immigrants. In addition, healthcare professionals in three hospitals that offer specialized health services to these city districts were included.

Even though the response rate was low in this study some interesting tendencies were uncovered. The study, in parallel with earlier studies, indicated that professional

interpreters were underutilized in the health sector, considering the frequency of the language barriers experienced by providers in the study. Further, the answers indicated that the use of interpreters as a working method was not sufficiently embedded in the healthcare services as a standardized and quality assured procedure. Therefore, the use of interpreters seemed to be somehow incidental and dependent on the health provider's own knowledge and initiative.

Responses indicated that situations where healthcare workers did not use interpreters, even though the patient's understanding of Norwegian was insufficient, occurred quite often (in 28.8% of cases with doctors and 41.5% of cases with nurses). Further 25.3% of respondents indicated that they had often conducted the first conversation with a patient without knowing whether the patient's understanding of Norwegian was adequate.

How do conversations take place when there is a language barrier and how does this affect the health outcomes? This survey did not give an answer to these questions. Well-known impacts when facing language barriers is the feeling of defeat, vulnerability and perhaps helplessness on the part of the patient, but also on the part of the health provider. From clinical experiences, it is known that patients can blame themselves for not being able to speak the majority language better and often feel ashamed about this. Sometimes they do not concede that they have language difficulties, instead pretending to understand.

In this study, a large percentage of the respondents answered that they often tried to communicate with the patient without an interpreter (33%) in acute situations. This is thought-provoking considering that such situations might involve life-threatening conditions. Further findings indicated that healthcare providers had a tendency to resort to solutions that are *most easily available*, for example, using family or friends as interpreters or trying to communicate with the patient in spite of language barriers. More than half of the physicians and nurses responded that they often communicated with the patient through family member(s) or friends. What were the reasons for not using professional language assistance? The healthcare workers stated often that the reasons for not arranging an interpreter were impracticality, it being too time-consuming and poor access to interpreter services.

Further, a considerable percentage of the survey participants expressed dissatisfaction with both their own methods of working with interpreters and with the interpreter's qualifications.

5.3.2 Implications of this study for healthcare services

One of the implications of this study is that the existing practices can have negative consequences for equal access to healthcare services for patients with limited majority language proficiency and inadequate health literacy. The Patient Rights Law in Norway places the responsibility on healthcare workers and healthcare institutions to guarantee the patient's right to information and input by providing optimal communication with patients. The healthcare providers, who usually have no training in how to evaluate patients' language abilities, seem often to be left alone to make the decisions. A newly conducted study indicates that healthcare providers and patients might evaluate quite differently whether or not a language barrier exists (Le C, 2011). Therefore, it is important that administrators at healthcare services and healthcare policy makers are aware of their responsibility to secure the knowledge base and procedures necessary to fulfil the intention of the laws.

Better routines and procedures in the workplace for the effective organization of work with interpreters and a higher awareness and competence at the institutional level about which measures should be taken in order to adapt healthcare services for patients with limited majority language proficiency and inadequate health literacy are recommended.

Before the consultation

- Prefer professional interpreters rather than ad hoc solutions with for example family members
- Set up time to meet the interpreter to explain the goal of the consultation
- Check if the interpreter's background characteristics and position in the community might affect the relationship between interpreter and the patient negatively
- Explain the field in which the interpretation is needed and some specifics aspects of the topic which the interpreter should be aware of and prepared for
- Inform the interpreter briefly about your methods and approaches
- Agree upon a cooperation model

During the consultation

- Sit in a triangle such that you face the patient and the interpreter is sitting beside both of you
- Ensure that the interpreter always explains his/her role and gives information about the confidentiality rule at the beginning of the consultation
- Look at the patient when the interpreter speaks
- Use direct speech (e.g., "you" instead of "tell her/him that…)"
- Avoid long sentences and jargon
- Be aware of signals from the patient and the interpreter about the quality of the communication and interaction
- To secure effective communication ask control question to the patient, for example, ask what he/she understood of the information/instructions you have just given
- Do not involve the interpreter as a cultural broker or mediator, unless he/she has a defined role as such
- Be aware that mediated communication is different than direct immediate communication, and has its own limits

After the consultation

- Give a debriefing to the interpreter if it has been a difficult consultation emotionally
- Evaluate the cooperation and give feedback
- Use the same interpreter if possible to assist in developing a professional working alliance being established between you and the interpreter, as well as between the patient and the interpreter - this can be especially important in mental health services

Box 2. Some recommendations for working with interpreters in medical settings

6. Conclusions

- With over 200 million migrants in the world today, steadily increasing migration is a key driver of multiethnic societies.
- Multi-ethnic societies multiply the challenges for healthcare and these range from varying health behaviours, beliefs and attitudes, diseases, communication, language and cultural barriers, requirements based on religion, lack of information, personal biases, stereotyped views, individual racism to institutional (health system) bias and enforcement of laws requiring equal opportunities in employment and other walks of public life.

- Unless there is a focus on health inequities disadvantaged groups will not have a fair opportunity to attain their full health potential. Health equity should not only be seen in the light of rights, laws and at the macro level of health systems, but also in access and quality of care and equal utilization for equal need.
- Communication in healthcare is influenced by many factors. Language barriers and inadequate health literacy can, among other things, influence communication negatively in healthcare encounters. It seems that the influence of these factors on communication and health outcomes are often underestimated by healthcare providers and policy makers.
- Existing legislation in several countries has increased emphasis on patient rights and the legal strengthening of these rights. This implies that healthcare workers and healthcare institutions have the responsibility to guarantee the patient's right to information by providing optimal communication with patients and communication should be adapted to patient needs.
- An optimal way to overcome language barriers is to ensure the assistance of professional interpreters, but studies mentioned above indicate that the decision-making of healthcare providers regarding whether or not professional language assistance is needed is often influenced by hectic working conditions, making the providers resort to solutions that are most easily available, but not necessarily optimal.
- These practices can have negative consequences for equal access to healthcare services for patients with limited majority language proficiency and inadequate health literacy.
- Finally, given that multi-ethnic societies are here to stay, further operational research and development, and implementation of good practices are critical to both tackling health inequities and overcoming barriers in communication.

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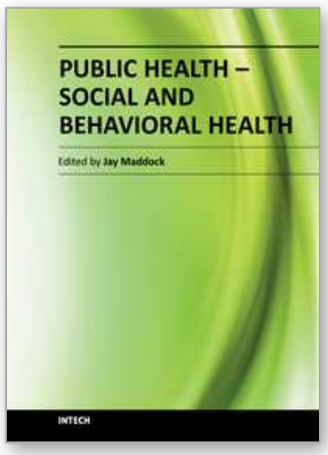

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